

Claimocity MIPS

Frequently Asked Questions

This FAQ covers questions about MIPS eligibility, measures, reporting, and workflows. Please feel free to use the table of contents below to help you quickly find the information you need:

1) What is MIPS?	2
2) Do I have to participate in MIPS?	2
3) How do I know if I am required to report as an individual or as part of a group?	3
4) What happens if I do not report MIPS?	3
5) How do I check my MIPS eligibility?	4
6) Are there any common MIPS exclusions or exceptions?	4
7) What are the four MIPS performance categories?	5
8) How do we choose which MIPS measures to report?	5
9) What reporting options are available for MIPS?	6
10) Do inpatient or hospital-based providers have different MIPS rules?	6
11) Do I need to manually report Quality measures?	7
12) What is Promoting Interoperability, and do hospital-based providers need to report it?	7
13) What are Improvement Activities?	7
14) What about the Cost category?	8
15) How do MIPS measures work inside Claimocity?	8
16) Why are some MIPS measures not triggering?	9
17) How is MIPS reporting handled with Claimocity?	9
18) Does Claimocity report MIPS on our behalf?	9
LEARN MORE	10

1) What is MIPS?

MIPS, or the **Merit-Based Incentive Payment System**, is a Medicare program that adjusts future Medicare reimbursement based on performance. Depending on your score, your Medicare payments may increase, decrease, or stay the same.

CMS evaluates eligible providers across four performance categories:

- **Quality**
- **Cost**
- **Improvement Activities**
- **Promoting Interoperability**

For many providers, MIPS is more than a reporting requirement. It can directly affect future revenue.

Resource: [How Providers Know If They Need to Participate in MIPS](#)

2) Do I have to participate in MIPS?

Not always. MIPS participation depends on whether CMS determines that you meet the annual eligibility thresholds.

For 2026, CMS looks at these three thresholds:

- **\$90,000 or more in Medicare Part B allowed charges**
- **200 or more Medicare Part B patients**
- **200 or more covered professional services under Medicare Part B**

Your status generally falls into one of three categories:

- **Required to report** if you exceed all three thresholds
- **Opt-in eligible** if you meet one or two thresholds
- **Excluded** if you do not meet any of the thresholds

CMS determines eligibility using prior billing history, so your current year activity does not determine your status for that same year.

Resource: [How Providers Know If They Need to Participate in MIPS](#)

[Back to Table of Contents](#)

3) How do I know if I am required to report as an individual or as part of a group?

MIPS eligibility is determined at the individual provider level using your NPI, not at the group level. Even if you are part of a larger group practice, your own Medicare billing history determines whether you are required to participate.

When checking your status in the CMS QPP participation tool:

✓ **Green check mark next to your individual name**

- Means you are required to report individually

✓ **Green check mark only next to the group name**

- Means you are NOT required to report individually

✗ **No check mark**

- May indicate you are below thresholds or excluded

Once eligibility is confirmed, your organization should also determine whether **individual reporting**, **group reporting**, or **facility-based scoring** is the best fit operationally.

Resources:

[How Providers Know If They Need to Participate in MIPS](#)

[What MIPS Measures Should I Report?](#)

4) What happens if I do not report MIPS?

If you are required to report and do not submit MIPS data, you may receive a negative payment adjustment on future Medicare reimbursements.

MIPS is tied to future payment, so not reporting can have a direct financial impact on your practice. On the other hand, strong performance may support neutral or positive payment adjustments.

Resource: [How Providers Know If They Need to Participate in MIPS](#)

[Back to Table of Contents](#)

5) How do I check my MIPS eligibility?

CMS provides a participation lookup tool through the QPP portal. To check your status:

- 1) Go to the [CMS QPP participation status tool](#)
- 2) Enter your NPI (National Provider Identifier)
- 3) Review your result

Possible outcomes include:

- ✓ **Green check mark next to your individual name**
 - Means you are required to report individually
- ✓ **Green check mark only next to the group name**
 - Means you are NOT required to report individually
- ✗ **No check mark**
 - May indicate you are below thresholds or excluded

Important Note: Eligibility can change from year to year; it is important to check annually. We recommend checking early in the year, ideally in February or March, so there is enough time to prepare if reporting is required.

Resource: [How Providers Know If They Need to Participate in MIPS](#)

6) Are there any common MIPS exclusions or exceptions?

Yes. Some providers may be excluded from MIPS even if they are otherwise familiar with the program.

Examples include:

- **Newly enrolled Medicare clinicians** in their first year of Medicare participation
- **Advanced APM participants** who meet Advanced APM thresholds
- **Hospital-based clinicians** who provide **75% or more** of their services in inpatient hospital or emergency department settings

These exclusions can significantly affect whether reporting is required and how your score is calculated.

Resource: [How Providers Know If They Need to Participate in MIPS](#)

[Back to Table of Contents](#)

7) What are the four MIPS performance categories?

MIPS performance is scored across four categories. For the 2026 performance year:

- **Quality – 30%**
 - Measures clinical outcomes and processes
- **Cost – 30%**
 - Evaluates cost efficiency using Medicare claims
- **Promoting Interoperability – 25%**
 - Assesses use of certified EHR technology
- **Improvement Activities – 15%**
 - Recognizes practice improvement efforts

For many hospital-based providers, these weights may be adjusted based on exemptions and reweighting rules.

Resource: [What MIPS Measures Should I Report?](#)

8) How do we choose which MIPS measures to report?

Measure selection should be based on your:

- Specialty
- Patient population
- Practice setting
- Documentation workflow
- Reporting structure

Inpatient and facility-based providers often need a different approach than outpatient practices. For hospitalists and similar specialties, the best measures are typically the ones that align with actual workflows, reporting structure, and available documentation.

If your team is eligible for facility-based scoring or group reporting, that may also affect which measures matter most.

Resource: [What MIPS Measures Should I Report?](#)

[Back to Table of Contents](#)

9) What reporting options are available for MIPS?

After confirming eligibility, the next step is understanding how your organization will report.

- **Individual reporting**
 - MIPS data is tied to each provider's NPI. This may work well for solo providers or clinicians with unique practice patterns.
- **Group reporting**
 - Results are combined under one Tax Identification Number (TIN). This is common for hospitalist groups and can simplify the submission process.
- **Facility-based scoring**
 - If **75% or more** of your group's encounters occur in inpatient or emergency settings, CMS may use the hospital's quality data to calculate your score automatically.

The right approach depends on your organization's structure and workflow.

Resource: [What MIPS Measures Should I Report?](#)

10) Do inpatient or hospital-based providers have different MIPS rules?

Yes. Claimocity's blog highlights that inpatient providers often have different reporting considerations than outpatient clinicians.

For example:

- Many hospital-based groups qualify for **automatic facility-based scoring**
- Many hospital-based clinicians qualify for **Promoting Interoperability reweighting**
- Cost is generally calculated by CMS from claims rather than manually submitted
- Improvement Activities may better reflect inpatient workflows such as discharge coordination, team-based care, and safety protocols

Due to this, inpatient MIPS strategy often looks different from traditional outpatient measure selection.

Resource: [What MIPS Measures Should I Report?](#)

[Back to Table of Contents](#)

11) Do I need to manually report Quality measures?

Not always.

According to Claimocity's guide, many inpatient providers qualify for automatic facility-based scoring if **75% or more** of the group's services occur in inpatient or emergency settings. In those cases, CMS may calculate the Quality score using the hospital's Hospital Value-Based Purchasing data.

If your organization does not qualify for facility-based scoring, Quality data may need to be submitted manually through:

- **A registry or QCDR**
- **An EHR vendor**
- **The CMS QPP portal**
- **An MVP reporting pathway**, when applicable

Resource: [What MIPS Measures Should I Report?](#)

12) What is Promoting Interoperability, and do hospital-based providers need to report it?

Promoting Interoperability, or PI, measures how well providers use certified EHR technology.

For many hospital-based clinicians, PI is automatically reweighted to **0%** because they do not control their facility's EHR system. When that happens, those points are redistributed to other categories, often increasing the weight of Quality.

If your group controls its own EHR or chooses to report PI voluntarily, then PI requirements may still apply.

Resource: [What MIPS Measures Should I Report?](#)

13) What are Improvement Activities?

Improvement Activities are actions your practice takes to improve care delivery, safety, coordination, or operational quality.

This category makes up **15%** of the MIPS score and often aligns well with inpatient workflows.

[Back to Table of Contents](#)

Examples may include:

- Medication reconciliation
- Fall prevention efforts
- Multidisciplinary rounds
- Care transition programs
- Safety protocols around AI-supported clinical tools

Generally, practices need to report two medium-weighted activities or one high-weighted activity performed for **at least 90 consecutive days**.

Resource: [What MIPS Measures Should I Report?](#)

14) What about the Cost category?

The Cost category is based on Medicare administrative claims, not manual submission.

For inpatient clinicians, this means CMS calculates cost performance automatically using episode-based cost measures. While you do not submit Cost data yourself, it can still significantly affect your overall score.

As a result, it is helpful to review CMS feedback and understand how cost episodes are being attributed to your practice.

Resource: [What MIPS Measures Should I Report?](#)

15) How do MIPS measures work inside Claimocity?

MIPS measures in Claimocity depend on documentation, workflow, and setup. Measures may be triggered by encounter details such as diagnoses, note content, and other required clinical documentation.

Proper configuration and complete documentation are important for helping measures fire correctly and for supporting accurate reporting.

Resources:

[How to Add MIPS Measures](#)

[P360 & MIPS Overview](#)

[Back to Table of Contents](#)

16) Why are some MIPS measures not triggering?

A measure may not trigger for several reasons, including:

- Required documentation is missing
- The encounter does not meet the measure criteria
- The measure is not configured in the workflow
- The selected reporting setup does not align with the provider's specialty or reporting method

When this happens, reviewing both the documentation requirements and the reporting setup is important. If the issue persists, your Claimocity team can review the configuration and workflow setup.

Resource: [How to Add MIPS Measures](#)

17) How is MIPS reporting handled with Claimocity?

Claimocity helps simplify MIPS reporting by capturing the relevant performance data during the provider workflow. As providers document patient encounters, the system organizes the information needed for MIPS reporting.

For customers using [Patient360](#), Claimocity integrates with the Patient360 CMS-qualified registry, which supports the submission of MIPS performance data to CMS.

This allows providers to focus on documentation and patient care while reporting data is organized through the integrated workflow.

Resource: [P360 & MIPS Overview](#)

18) Does Claimocity report MIPS on our behalf?

Claimocity works with [Patient360](#), a CMS-qualified registry, to support reporting workflows. Claimocity captures relevant performance data during the provider workflow, and Patient360 supports submission to CMS.

At the same time, practices are still responsible for core decisions such as:

- **Confirming whether reporting is required**
- **Choosing the right reporting path**
- **Selecting measures that fit their practice**

Claimocity helps reduce administrative burden, organize the data, and support the process.

[Back to Table of Contents](#)

LEARN MORE

Claimocity Blogs

- [How Providers Know If They Need to Participate in MIPS](#)
- [What MIPS Measures Should I Report?](#)

Claimocity Help Center

- [How to Add MIPS Measures](#)
- [P360 & MIPS Overview](#)

Additional CMS Resources

- [QPP Resource Library](#)
- [QPP Participation Status Tool](#)
- [QPP Measure Explorer](#)
- [2026 MIPS Payment Adjustment User Guide](#)
- [2026 QPP Final Rule Fact Sheet & Policy Comparison Table](#)
- [2026 Benchmark Files](#)

[Back to Table of Contents](#)